

# **REASSESSMENT STANDARDS**

## **A. REGULATION AND POLICY**

To provide a quality, effective system of emergency medical care, each EMS system must have in place comprehensive enabling legislation with provision for a lead EMS agency. This agency has the authority to plan and implement an effective EMS system, and to promulgate appropriate rules and regulations for each recognized component of the EMS system (authority for statewide coordination; standardized treatment, transport, communication and evaluation, including licensure of out-of-hospital services and establishment of medical control; designation of specialty care centers; PIER programs). There is a consistent, established funding source to adequately support the activities of the lead agency and other essential resources which are necessary to carry out the legislative mandate. The lead agency operates under a single, clear management structure for planning and policy setting, but strives to achieve consensus among EMS constituency groups in formulating public policy, procedures and protocols. The role of any local/regional EMS agencies or councils who are charged with implementing EMS policies is clearly established, as well as their relationship to the lead agency. Supportive management elements for planning and developing effective statewide EMS systems include the presence of a formal EMS Medical Director, a Medical Advisory Committee for review of EMS medical care issues and an EMS Advisory Committee (or Board). The EMS Advisory Committee has a clear mission, specified authority and representative membership from all disciplines involved in the implementation of EMS systems.

## **B. RESOURCE MANAGEMENT**

Central coordination and current knowledge (identification and categorization) of system resources is essential to maintain a coordinated response and appropriate resource utilization within an effective EMS system. A comprehensive State EMS plan exists which is based on a statewide resource assessment and updated as necessary to guide EMS system activities. A central statewide data collection (or management information) system is in place that can properly monitor the utilization of EMS resources; data is available for timely determination of the exact quantity, quality, distribution and utilization of resources. The lead agency is adequately staffed to carry out central coordination activities and technical assistance. There is a program to support recruitment and retention of EMS personnel, including volunteers.

## **C. HUMAN RESOURCES AND TRAINING**

EMS personnel can perform their mission only if adequately trained and available in sufficient numbers throughout the State. The State EMS lead agency has a mechanism to assess current manpower needs and establish a comprehensive plan for stable and consistent EMS training programs with effective local and regional support. At a minimum, all transporting out-of-hospital emergency medical care personnel are trained to the EMT-Basic level, and prehospital training programs utilize a standardized curriculum for each level of EMT personnel (including EMS dispatchers). EMS training programs and instructors are routinely monitored, instructors meet certain requirements, the curriculum is standardized throughout the State, and valid and reliable testing procedures are utilized. In addition, the State lead agency has standardized, consistent policies and procedures for certification (and re-certification) of personnel, including standards for basic and advanced level providers, as well as instructor certification. The lead agency ensures that EMS personnel have access to specialty courses such as ACLS, PALS, BTLs, PHTLS, ATLS, etc., and a system of critical incident stress management has been implemented.

## **D. TRANSPORTATION**

Safe, reliable ambulance transportation is a critical component of an effective EMS system. The transportation component of the State EMS plan includes provisions for uniform coverage, including a protocol for air medical dispatch and a mutual aid plan. This plan is based on a current, formal needs assessment of transportation resources, including the placement and deployment of all out-of-hospital emergency medical care transport services. There is an identified ambulance placement or response unit strategy, based on patient need and optimal response times. The lead agency has a mechanism for routine evaluation of transport services and the need for modifications, upgrades or improvements based on changes in the environment (i.e., population density). Statewide, uniform standards exist for inspection and licensure of all modes of transport (ground, air, water) as well as minimum care levels for all transport services (minimum staffing and credentialing). All out-of-hospital emergency medical care transport services are subject to routine, standardized inspections, as well as “spot checks” to maintain a constant state of readiness throughout the state. There is a program for the training and certification of emergency vehicle operators.

## **E. FACILITIES**

It is imperative that the seriously ill patient be delivered in a timely manner to the closest appropriate facility. The lead agency has a system for categorizing the functional capabilities of all individual health care facilities that receive patients from the out-of-hospital emergency medical care setting. This determination should be free of political considerations, is updated on an annual basis and encompasses both stabilization and definitive care. There is a process for verification of the categorizations (i.e., on-site review). This information is disseminated to EMS providers so that the capabilities of the facilities are known in advance and appropriate primary and secondary transport decisions can be made. The lead agency also develops and implements out-of-hospital emergency medical care triage and destination policies, as well as protocols for specialty care patients (such as severe trauma, burns, spinal cord injuries and pediatric emergencies) based on the functional assessment of facilities. Criteria are identified to guide interfacility transport of specialty care patients to the appropriate facilities. Diversion policies are developed and utilized to match system resources with patient needs; standards are clearly identified for placing a facility on bypass or diverting an ambulance to another facility. The lead agency has a method for monitoring if patients are directed to appropriate facilities.

## **F. COMMUNICATIONS**

A reliable communications system is an essential component of an overall EMS system. The lead agency is responsible for central coordination of EMS communications (or works closely with another single agency that performs this function) and the state EMS plan contains a component for comprehensive EMS communications. The public can access the EMS system with a single, universal phone number, such as 9-1-1 (or preferably Enhanced 9-1-1), and the communications system provides for prioritized dispatch. There is a common, statewide radio system that allows for direct communication between all providers (dispatch to ambulance communication, ambulance to ambulance, ambulance to hospital, and hospital to hospital communications) to ensure that receiving facilities are ready and able to accept patients. Minimum standards for dispatch centers are established, including protocols to ensure uniform dispatch and standards for dispatcher training and certification. There is an established mechanism for monitoring the quality of the communication system, including the age and reliability of equipment.

## **G. PUBLIC INFORMATION, EDUCATION AND PREVENTION**

To effectively serve the public, each state must develop and implement an EMS public information, education and relations (PIER) program. The PIER component of the State EMS plan ensures that consistent, structured PIER programs are in place that enhance the public's knowledge of the EMS system, support appropriate EMS system access, demonstrate essential self-help and appropriate bystander care actions, and encourage injury prevention. The PIER plan is based on a needs assessment of the population to be served and an identification of actual or potential problem areas (e.g., demographics and health status variable, public perceptions and knowledge of EMS, type and scope of existing PIER programs). There is an established mechanism for the provision of appropriate and timely release of information on EMS-related events, issues and public relations (damage control). The lead agency dedicates staffing and funding for these programs, which are directed at both the general public and EMS providers. The lead agency enlists the cooperation of other public service agencies in the development and distribution of these programs, and serves as an advocate for legislation that potentially results in injury/illness prevention.

## **H. MEDICAL DIRECTION**

EMS is a medical care system that involves medical practice as delegated by physicians to non-physician providers who manage patient care outside the traditional confines of office or hospital. As befits this delegation of authority, the system ensures that physicians are involved in all aspects of the patient care system. The role of the State Medical Director for EMS is clearly defined, with legislative authority and responsibility for EMS system standards, protocols and evaluation of patient care. A comprehensive system of medical direction for all out-of-hospital emergency medical care providers (including ELS) is utilized to evaluate the provision of medical care as it relates to patient outcome, appropriateness of training programs and medical direction. There are standards for the training and monitoring of direct medical control physicians, and statewide, standardized treatment protocols. There is a mechanism for concurrent and retrospective review of out-of-hospital emergency medical care, including indicators for optimal system performance. Physicians are consistently involved and provide leadership at all levels of quality improvement programs (local, regional, statewide).

## **I. TRAUMA SYSTEMS**

To provide a quality, effective system of trauma care, each State must have in place a fully functional EMS system; trauma care components must be clearly integrated with the overall EMS system. Enabling legislation should be in place for the development and implementation of the trauma care component of the EMS system. This should include trauma center designation (using ACS-COT, APSA-COT and other national standards as guidelines), triage and transfer guidelines for trauma patients, data collection and trauma registry definitions and mechanisms, mandatory autopsies and quality improvement for trauma patients. Information and trends from the trauma registry should be reflected in PIER and injury prevention programs. Rehabilitation is an essential component of any statewide trauma system and hence these services should also be considered as part of the designation process. The statewide trauma system (or trauma system plan) reflects the essential elements of the Model Trauma Care System Plan.

## **J. EVALUATION**

A comprehensive evaluation program is needed to effectively plan, implement and monitor a statewide EMS system. The EMS system is responsible for evaluating the effectiveness of services provided victims of medical or trauma related emergencies, therefore the EMS agency should be able to state definitively what impact has been made on the patients served by the system. A uniform, statewide out-of-hospital data collection system exists that captures the minimum data necessary to measure compliance with standards (i.e., a mandatory, uniform EMS run report form or a minimum set of data that is provided to the state); data are consistently and routinely provided to the lead agency by all EMS providers and the lead agency performs routine analysis of this data. Pre-established standards, criteria and outcome parameters are used to evaluate resource utilization, scope of services, effectiveness of policies and procedures, and patient outcome. A comprehensive, medically directed statewide quality improvement program is established to assess and evaluate patient care, including a review of process (how EMS system components are functioning) and outcome. The quality improvement program should include an assessment of how the system is currently functioning according to the performance standards, identification of system improvements that are needed to exceed the standards and a mechanism to measure the impact of the improvements once implemented. Patient outcome data is collected and integrated with emergency department and trauma system data; optimally there is linkage to data bases outside of EMS (such as crash reports, FARS, trauma registry, medical examiner reports and discharge data) to fully evaluate quality of care. The evaluation process is educational and quality improvement/system evaluation findings are disseminated to out-of hospital emergency medical care providers. The lead agency ensures that all quality improvement activities have legislative confidentiality protection and are non-discoverable.